BOCA RATON **FAMILY & PEDIATRIC CLINIC**
Luis Alvarez, MD (Family Physician) • Sandra Alvarez, MD (Pediatrician)
19801 Hampton Drive, Suite C2, Boca Raton, FL 33434 • 561-477-2862 • 561-477-2864 (FAX)

E-SIGNATURE CONSENT

E SIGNATURE CONSENT DISCLOSURE AND RELEASE

CONSENT AND NOTICE REGARDING ELECTRONIC COMMUNICATIONS

If you intend to electronically sign the following form, please read this carefully before signing.

1. Electronic Signature Agreement:

BY SELECTING THE PRINTING AND SIGNING* YOU ARE SIGNING THIS AGREEMENT AND ALL AGREEMENT(S) ATTACHED HEREIN ELECTRONICALLY. **YOU AGREE YOUR ELECTRONIC SIGNATURE IS THE LEGAL EQUIVALENT OF YOUR MANUAL SIGNATURE ON THIS AGREEMENT** AND ALL ATTACHED AGREEMENT(S). BY SIGNING* **YOU CONSENT TO BE LEGALLY BOUND BY THIS AGREEMENT'S TERMS AND CONDITIONS. YOU FURTHER AGREE THAT YOUR USE OF A KEY PAD, MOUSE OR OTHER DEVICE TO SELECT AN ITEM, BUTTON, ICON OR SIMILAR ACT/ACTION IN ANY AGREEMENT, ACKNOWLEDGEMENT, CONSENT TERMS, DISCLOSURES OR CONDITIONS CONSTITUTES YOUR SIGNATURE (HEREAFTER REFERRED TO AS "E-SIGNATURE"), ACCEPTANCE AND AGREEMENT AS IF ACTUALLY SIGNED BY YOU IN WRITING.** YOU ALSO AGREE THAT NO CERTIFICATION AUTHORITY OR OTHER THIRD PARTY VERIFICATION IS NECESSARY TO VALIDATE YOUR E-SIGNATURE AND THAT THE LACK OF SUCH CERTIFICATION OR THIRD PARTY VERIFICATION WILL NOT IN ANY WAY AFFECT THE ENFORCEABILITY OF YOUR E-SIGNATURE OR ANY RESULTING CONTRACT BETWEEN YOU AND BRF&PC. YOU ALSO REPRESENT THAT YOU ARE AUTHORIZED TO ENTER INTO THIS AGREEMENT FOR ALL PERSONS WHO OWN OR ARE AUTHORIZED TO ACCESS ANY OF YOUR RECORDS AND THAT SUCH PERSONS WILL BE BOUND BY THE TERMS OF THIS AGREEMENT. YOU FURTHER AGREE THAT EACH USE OF YOUR E-SIGNATURE IN OBTAINING BRF&PC SERVICES CONSTITUTES YOUR AGREEMENT TO BE BOUND BY THE TERMS AND CONDITIONS OF THE BRF&PC.

2. Consent to Electronic Delivery:

You specifically agree to receive and/or obtain any or all **BRF&PC** related "Electronic Communications" (defined below): BRF&PC The term "Electronic Communications" includes, but is not limited to,any and all current and future notices and/or disclosures that various federal and/or state laws or regulations require that we provide to you, as well as such other documents,statements, data, records and any other communications You acknowledge that, BRF&PC may retain Electronic Communications by printing and/or downloading and saving this Agreement and any other agreements and Electronic Communications, documents, or records that you agree to using your E-Signature. You accept Electronic Communications provided via BRF&PC as reasonable and propernotice, for the purpose of any and all laws, rules, and regulations, and agree that suchelectronic form fully satisfies any requirement that such communications be provided to you in writing or in a form that you may keep.

3. Paper version of Electronic Communications:

You may request a paper version of anElectronic. You acknowledge that BRF&PC reserves the right to charge you a reasonable fee for the production and mailing of paper versions of Electronic Communications. To request a paper copy of an Electronic Communication contact us.

I HAVE READ AND UNDERSTAND THIS NOTICE

I, _____ HAVE READ AND UNDERSTAND THE TERMS ABOVE FOR
PRINTED NAME OF PATIENT

E-SIGNATURES AND AGREE TO IT'S TERMS

_____ **SIGNATURE**

___/___/___ **DATE**

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PATIENT INFORMATION

DATE ___/___/___

LAST NAME FIRST NAME MIDDLE

ADDRESS

ADDRESS

CITY STATE ZIP CODE

RESPONSIBILITY PARTY (IF PATIENT IS UNDER 18)

SEX ☐ MALE ☐ FEMALE

SOCIAL SECURITY #

___/___/___
DOB

AGE

☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ MINOR

☐ SEPERATED ☐ DIVORCED ☐ PARTNERED ____ YRS

OCCUPATION

EMPLOYER/SCHOOL

SPOUSE'S NAME

WHO MAY WE THANK FOR REFFERING YOU?

☐ _____ PHYSICIAN
☐ _____ FRIEND
☐ _____ OTHER

☐ YELLOW PAGES
☐ INTERNET
☐ SOCIAL MEDIA
☐ INSURANCE

INSURANCE

WHO IS RESPONSIBLE FOR THIS ACCOUNT?

RELATIONSHIP TO PATIENT

INSURANCE COMPANY

DRIVERS LICENSE OR IDENTIFICATION OR PASSPORT #

GROUP #

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to Dr. Luis Alvarez and/or Dr. Sandra Alvarez all insurance benefits, and if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the data signed below.

SIGNATURE ___/___/___ DATE

PRINT NAME RELATIONSHIP TO PATIENT

PHONE NUMBERS

HOME PHONE MOBILE WORK PHONE

EMAIL ADDRESS SPOUSE PHONE/MOBILE

IN CASE OF EMERGENCY FIRST, LAST NAME HOME PHONE MOBILE

PHARMACY NAME PHARMACY NUMBER

MEDICATIONS LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING

MEDICATION STRENGTH TIMES PER DAY

ALLERGIES PLEASE CHECK ANY ALLERGIES AND/OR FILL IN BELOW

☐ ASPIRIN
☐ BARBITURATES (SLEEPING PILLS)
☐ CODEINE
☐ IODINE
☐ SULFATE
☐ OTHER:

☐ LATEX
☐ LOCAL ANESTHETIC
☐ PENICILLIN
☐ NONE

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MEDICAL HISTORY

- ☐ ALLERGIES
- ☐ ANXIETY
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BACKACHES
- ☐ INCONTINENCE
- ☐ CANCER
- ☐ COLITIS
- ☐ DEPRESSION
- ☐ DIABETES
- ☐ DRINKING DISORDER
- ☐ ECZEMA
- ☐ FATIGUE
- ☐ FREQUENT INFECTIONS
- ☐ HEADACHES
- ☐ HEART ATTACK
- ☐ HEART DISEASE
- ☐ HERNIA
- ☐ HYPERTENSION
- ☐ HYPOGLYYCEMIA
- ☐ INSOMNIA
- ☐ IRRITABILITY
- ☐ KIDNEY PROBLEMS
- ☐ METAL IMPLANTS
- ☐ MIGRAINES NERVOUS
- ☐ DISORDERS
- ☐ PACEMAKER
- ☐ PALPATATIONS
- ☐ PREGNANT
- ☐ RHEHMATIC FEVER
- ☐ SEIZURES
- ☐ SEXUAL DISINTEREST
- ☐ SKIN PROBLEMS
- ☐ SURGERIES
- ☐ TUMOR
- ☐ ULCERS
- ☐ WEIGHT FLUCTUATION
- ☐ WEIGHT PROBLEMS
- ☐ OTHER _____

DO YOU WEAR CONTACT LENSES? ☐ YES ☐ NO

(WOMEN) ARE YOU PREGNANT? ☐ YES ☐ NO

IS THERE ANYONE IN YOUR FAMILY WHO HAS DIED BEFORE THE AGE OF 40? IF YES, WHO AND WHY DID THEY DIE?

_____

HAVE YOU EVER HAD TO SEE A DOCTOR OR GO TO THE HOSPITAL DUE TO A MENTAL OR BEHAVIORAL PROBLEM?

☐ YES ☐ NO

_____

IF YES, WHEN AND WHY?

FLORIDA MEDICAL ASSOCIATION, HIPPA AND FINANCIAL RESPONSIBILITY

THE FLORIDA MEDICAL ASSOCIATION

THE CURRENT PROFESSIONAL LIABILITY INSURANCE CRISIS IN FLORIDA AFFECTS YOU AND EVERY OTHER PATIENT. BECAUSE MANY PHYSICIANS ARE BEING FORCED TO STOP PERFORMING CERTAIN PROCEDURES, RETIRE EARLY OR LEAVE TO PRACTICE IN OTHER STATES WHERE PREMIUMS ARE LOWER, PATIENTS ARE LOSING ACCESS TO THEIR PHYSICIAN. AT A TIME WHEN FLORIDA'S POPULATION HAS GROWN FASTER THAN ANY STATE, 63 HOSPITALS HAVE CLOSED IN THE PAST 15 YEARS. PATIENT CARE IS AT RISK; PEOPLE HAVE LESS ACCESS. IN ORDER TO ENSURE YOUR CONTINUED ACCESS TO PHYSICIANS IN FLORIDA, I AM ASKING YOU TO SIGN THE BELOW NOTICE. IF YOU DO NOT UNDERSTAND THIS FORM, YOU HAVE THE RIGHT TO TAKE IT TO YOUR ATTORNEY TO HAVE HIM OR HER EXPLAIN THE FORM TO YOU. **YOU MAY CONSULT WITH AN ATTORNEY BEFORE SIGNING THIS FORM**. WAIVER OF THE CONSTITUTIONAL RIGHT PROVIDED IN **ARTICLE 1, SECTION 21, FLORIDA CONSTITUTION**. ACCESS TO COMIS - THE COURTS SHALL BE OPEN TO EVERY PERSON FOR REDRESS OF ANY INJURY, AND JUSTICE SHALL BE ADMINISTERED WITHOUT SALE, DENIAL OR DELAY. ***I HAVE BEEN ADVISED THAT SIGNING THIS WAIVER RELEASES AN IMPORTANT CONSTITUTIONAL RIGHT AND BY SIGNING THIS WAIVER I AGREE THAT IF ANY CONTROVERSY ARISES OUT OF OR IN ANY WAY RELATING TO THE CURRENT, FUTURE OR PAST DIAGNOSIS, TREATMENT OR CARE THTAT I HAVE OR WILL RECEIVE FROM THE PHYSICIAN OR GROUP OF PHYSICIANS LISTED BELOW, OR THE PHYSICIAN(S)'S AGENTS OR EMPLOYEES, THE MAXIMUM AMOUNT OF ANY NON-ECONOMIC DMANAGES THAT CAN BE AWARDED IN ANY SUCH ACTION WILL BE $250,000.*** THIS LIMIT APPLIES REGARDLESS OF THE NUMBER OF CLAIMANTS OR DEFENDANTS IN THE PROCEEDING. THERE IS NO LIMIT ON THE AMOUNT OF ECONOMIC DAMAGES THAT A JURY MAY AWARD. BY SIGNING, I AGRE TOLET MY CASE GO TO ARBITRATION BEFORE MAKING A DECISION.

I HAVE READ & UNDERSTAND THIS NOTICE.

_____ ___/___/___

SIGNATURE **DATE**

HIPPA PRIVACY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED & HOW YOU CAN GET ACCESS TO IT - PLEASE REVIEW CAREFULLY. BOCA RATON FAMILY & PEDIATRIC CLINIC PROVIDES MANY TYPES OF HEALTH RELATED SERVICES. BRF&PC IS REQUIRED TO PROTECT THE INFORMATION WE COLLECT. THIS I NFORMATION IS CALLED "PROTECTED HEALTH INFORMATION" OR PHI. THIS NOTICE OF PRIVACY PRACTICES WILL TELL YOU HOW BRF&PC MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION. BRF&PC MAY USE AND DISCLOSE INFORMATION WITHOUT YOUR AUTHORIZATION FOR : **TREATMENT** WITH HEALTHCARE PROVIDERS WHO ARE INVOLVED WITH YOUR CARE. **PAYMENT:** TO RECIEVE PAYMENT OR TO PAY FOR THE HEALTH CARE SERVICES YOU RECIEVE. **HEALTH CARE OPERATIONS** IN ORDER TO MANAGE ITS PROGRAMS AND ACTIVITIES AND REVIEW THE SERVICES YOU RECIEVE. **APPOINTMENTS AND OTHER HEALTH INFORMATION:** TO SEND YOU REMINDERS FOR MEDICAL CARE OR CHECKUPS. **FOR PUBLIC HEALTH ACTIVITIES:** TO PUBLIC HEALTH AGENCY THAT KEEPS VITAL RECORDS AND TRACKS SOME DISEASES, AS REQUIRED BY LAW. **FOR HEALTH OVERSIGHT ACTIVITIES:** TO DISCLOSE INFORMATION TO INSPECT OR INVESTIGATE HEALTH PROVIDERS. **AS REQUIRED BY LAW:** TO DISCLOSE INFORMATION WHEN REQUIRED BY FEDERAL/STATE LAW OR COURT ORDER. **FOR GOVERNMENT PROGRAMS:** TO DISCLOSE INFORMATION FOR PUBLIC/GOVERNMENT BENEFITS. **TO AVOID HARM:** TO DISCLOSE TO LAW ENFORCEMENT IN ORDER TO AVOID A SERIOUS THREAT TO HEALTH/SAFETY. FOR OTHER SITUATIONS, BRF&PC WILL ASK YOU FOR YOUR WRITTEN AUTHORIZATION BEFORE USING OR DISCLOSING INFORMATION. YOU MAY CANCEL THIS AUTHORIZATION IN WRITING. BRF&PC CAN'T TAKE BACK AND USES OR DISCLOSURES ALREADY MADE WITH YOUR AUTHORIZATION.. OTHER LAWS PROTECT PHI.. YOUR PHI PRIVACTY RIGHTS: RIGHT TO SEE AND GET COPIES OF YOUR RECORDS, RIGHT TO REQUEST TO CORRECT OR UPDATE YOUR RECORDS, RIGHT TO GET A LIST OF DISCLOSURES, RIGHT TO REQUEST LIMITS ON USES OR DISCLOSURES OF PHI, RIGHT TO REVOKE PERMISSION, RIGHT TO CHOOSE HOW WE COMMUNICATE WITH YOU, RIGHT TO FILE A COMPLAINT, RIGHT TO GET A PAPER COPY OF THIS NOTICE. **PLEASE CONTACT LUIS A. ALVAREZ, M.D. OR SANDRA R ALVAREZ, M.D.** WITH ANY CONCERNS

GENERAL CONSENT FOR DIAGNOSIS AND TREATMENT AND FINANCIAL RESPONSIBILITY

I HEARBY CERITFY THAT I HAVE NOT KNOWINGLY WITHELD ANY INFORMATION ON INCOME OR OTHER FINANCIAL RESOURCES AND DISCOUNTS I HAVE DISCLOSED TO BE TRUE ANDCORRECT TO THE BEST OF MY KNOWLEDGE. THE UNDERSIGNED PATIENT AND/OR RESPONSIBLE PERSON OR RELATIVE HAVING **REGISTERED AT BOCA RATON FAMILY AND PEDIATRIC CLINIC** FOR THE PURPOSES OF OBTAINING HEALTH SERVICES, DO HERREBY, VOLUNTARILY CONSENT TO SUCH DIAGNOSTIC AND TREATMENT SERVICES, AS MIGHT BE PROVIDED BY OR AT THE DIRECTION OF A PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL OR OTHER QUALIFIED MEMBER OF THE STAFF OF THE BOCA RATON FAMILY AND PEDIACTRIC CLINIC TO ME ACCORINGN TO HIS/HER JUDGEMENT. I RECONIZE THAT I HAVE THE RIGHT TO REFUSE ANY SPECIFIC DIAGNOSTIC OR TREATMENT SERVICE WITHOUT JEOPARDIZING M Y RIGHT TO RECIEVE HEALTH SERVICES AT THE CENTER. I RECONIZE THAT I WILL BE ASKED TO SIGN A SPECIFIC CONSENT FOR SURGICAL AND OTHER SPECIAL PROCEDURES INCLUDING GENERAL AND/OR EXTENSIVE LOCAL ANESTHESIA. I AM AWARE THAT HEALTH SERVICES ARE NOT BASED ON AN EXACT SCIENCE, AND I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS THE RESULTS OF ANY TREATMENT SERVICES. I HEREBY AUTHORIZE PAYMENT OF HEALTH INSURANCE BENEFITS RECORDED ON THE REGISTRATION FORM TO BE PAID DIRECTLY BOCA RATON FAMILY AND PEDIACTRIC CLINIC FOR SERVICES PROVIDED. I HEREBY AUTHORIZE BOCA RATON FAMILY AND PEDIACTRIC CLINIC TO FURNISH SUCH INFORMATION FROM MY MEDICAL RECORD PERTAINING TO ANY AND ALL TREATMENT AS REQUESTED BY EITHER HEALTH INSURANCE PLANS OR FOR WHICH I AM RESPONSIBLE WILL REFLECT THE BALANCE DUE AFTER CREDIT FOR ALL APPROPRIATE DISCOUNTS AND ALL COLLECTIONS RECEIVED BY BOCA RATON FAMILY AND PEDIACTRIC CLINIC FROM HEALTH INSURANCE BENEFITS FOR THE ABOVE NAMED INDIVIDUALS. IF MY INSURANCE IS ACCEPTED, I UNDERSTAND MY CO-PAY IS DUE AT THE SAME TIME SERVICES ARE PROVIDED. I ALSO UNDERSTAND A RETURNED CHECK FEE OF $25.00 WILL BE CHARGED FOR ANY CHECK RETURNED TO US FOR NSF (NON-SUFFICIENT FUNDS) IF I WISH TO PAY BY PERSONAL CHECK.

I HAVE READ & UNDERSTAND THIS NOTICE.

_____ ___/___/___

SIGNATURE **DATE**

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OFFICE POLICIES

OFFICE HOURS

WE ARE HERE:	**MONDAY-THURSDAY:**	**9:00 AM - 5:00 PM**
	FRIDAY	**9:00 AM - 1:00 PM**
	SATURDAY-SUNDAY:	**CLOSED**

IF THIS IS A MEDICAL EMERGENCY PLEASE DIAL: 911

APPOINMENTS

PATIENTS WITH APPOINMENTS ARE GIVEN PRIORITY. AS A CONVENIENCE TO OUR PATIENTS, WE NOW ASK THAT YOU SCHEDULE YOUR APPOINMENTS. THIS WILL DECREASE THE WAIT TIME TO SEE OUR DOCTOR. OF COURSE PATIENTS WILL STILL BE ABLE TO WALK IN FOR EMERGENCIES.

PLEASE NOTE THAT FOR WALK-INS WE ONLY ACCEPT THEM MONDAY - THURSDAY 12PM - 3PM.

CO-PAYMENTS

ALL CO-PAYMENTS OR PAYMENT FOR OFFICE VISITS ARE DUE AT THE TIME SERVICES ARE RENDERED. CO-PAYMENTS ARE TYPICALLY COLLECTED BEFORE SEEING THE DOCTOR. WE ACCEPT CASH, PERSONAL CHECK, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER.

TO "WRITE OFF" A CO-PAY, OR TO ALLOW A PATIENT IN TO SEE THE DOCTOR WITHOUT COLLECTING THE CO-PAYMENT, IS AGAINST THE LAW.

FORMS OF PAYMENT WE DO TAKE

LABS:

AS A CONVENIENCE TO OUR PATIENTS, WE DRAW LABS IN THE OFFICE. WE USE PARTICIPATING LABS: QUEST AND LABCORP. IF A PATIENT PREFERS TO GO TO THE LAB INSTEAD, YOU WILL BE GIVEN A REQUISITION FOR BLOOD WORK. LAB RESULTS ARE DISCUSSED ONLY BY A FOLLOW UP. NO RESULTS WILL BE GIVEN OVER THE PHONE. IF A PATIENT PREFERS THEY BE EMAILED, FAXED OR MAILED INSTEAD OR IN ADDITION TO, THAT CAN BE ARRANGED. AGAIN, CO-PAYMENTS FOR ALL OFFICE VISITS ARE DUE AT EACH VISIT.

TO "WRITE-OFF" A CO-PAY, OR TO ALLOW A PATIENT IN TO SEE THEDOCTOR WITHOUT COLLECTING THE CO-PAYMENT, IS AGAINST THE LAW.

REFILL REQUESTS:

PLEASE CONTACT YOUR PHARMACY FOR ANY REFILL REQUEST. PLEASE ALLOW UP TO THREE(3) BUSINESS DAYS TO PROCESS YOUR REFILL REQUEST. PLEASE NOTE: THE DOCTOR WILL PRESCRIBE THREE(3) MONTHS OF MOST PRESCRIPTIONS AT A TIME. SOME PRESCRIPTIONS REQUIRE BY LAW THAT PATIENTS MUST BE SEEN ON A MONTHLY BASIS. PLEASE FOLLOW UP AND MAKE AN APPOINTMENT FOR YOUR NEXT VISIT.

ABSOLUTELY NO MEDICATIONS WILL BE CALLED IN AFTER HOURS AND ON WEEKENDS.

REFERRALS/AUTHORIZATIONS:

REFERRALS, AND AUTHORIZATIONS: ALLOW 7-10 DAYS MOST REQUESTS. ANY URGENT REQUESTS WILL BE HANDLED RIGHT AWAY. ALL INSURANCES ARE DIFFERENT: SOME REQUIRE LESS OR MORE TIME TO PROCESS. WE WILL TRY OUR BEST TO ACCOMODATE AND EXPEDITE YOUR REQUESTS.

FORMS/LETTERS/OTHER

PLEASE ALLOW AT LEAST ONE WEEK FOR ANY LETTERS, FORMS, OR ANY OTHER SPECIFIC REQUEST. AGAIN, WE WILL TRY OUR BEST TO ACCOMODATE AND EXPEDITE YOUR REQUESTS.

PHONE CALLS:

THE DOCTORS MAKE EVERY EFFORT TO RETURN CALLS BY THE SAME DAY, AFTER HOURS. IF YOU HAVE A MATTER THAT NEEDS TO BE ADDRESSED IMMEDIATELY, PLEASE MAKE A SAME DAY APPOINTMENT. IF YOU NEED TO MAKE AN APPOINTMENT, REQUEST RECORDS, REFERRALS, REFILLS, ETC. PLEASE SPEAK WITH OUR OFFICE STAFF.

OFFICE STAFF:

WE TREAT OUR PATIENTS WITH THE UPMOST IMPORTANCE. WE ASK THAT YOU DO THE SAME. ANY INAPPROPRIATE LANGUAGE OR BEHAVIOR WILL NOT BE TOLERATED

PRINTED NAME OF PATIENT _____ **SIGNATURE** _____ **DATE** / /

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MEDICAL RECORD REQUEST

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

NAME _____ PHONE NUMBER _____ DOB ___/___/___

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PLEASE RELEASE MY MEDICAL RECORDS FROM:

PROVIDER OR HOSPITAL _____

ADDRESS _____

ADDRESS _____

PHONE _____

FAX _____

TYPE OF RECORDS TO BE RELEASED:

PROGRESS NOTES, OPERATIVE NOTES, LABORATORY TEST RESULTS, DIAGNOSTICS TESTS, IMMUNIZATION RECORDS AND X-RAYS

_____ RECORDS OF CARE FROM ___/___/___ (DATE) TO ___/___/___ (DATE)

_____ RECORDS OF CARE CONCERNING THE FOLLOWING CONDITION(S):

_____

_____

_____ OTHER SPECIFY: _____

HIV, MENTAL HEALTH AND DRUG AND ALCOHOL INFORMATION CONTAINED IN THE PARTS OF THE RECORD INDICATED ABOVE WILL BE RELEASED THROUGH THIS AUTHORIZATION UNLESS OTHERWISE INDICATED. DO NOT RELEASE

☐ HIV ☐ MENTAL HEALTH (PSYCHIATRIC) ☐ DRUG AND ALCOHOL

I UNDERSTAND THAT THIS AUTHORIZATION IS EFFECTIVE FOR A PERIOD OF 90 DAYS FROM THE DATE OF SIGNATURE, UNLESS OTHERWISE SPECIFIED BELOW. NO TIME FRAME MAY EXCEED ONE YAR FROM THE DATE OF SIGNATURE. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BY SENDING A WRITTEN REQUEST TO THE ENTITY/PERSON I AUTHORIZED ABOVE TO RELEASE THE INFORMATION.

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS AS PROVIDED ABOVE.

PRINTED NAME OF PATIENT _____ SIGNATURE _____ DATE ___/___/___

PLEASE FAX TO: 561-477-2864

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PATIENT'S NAME _____ DOB ___/___/___

AUTHORIZATION TO ALLOW PERSON(S) TO DISCUSS MY MEDICAL RECORD HIPPA POLICY

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YOU MAY CANCEL THIS AUTHORIZATION IN WRITING. BRF&PC CAN'T TAKE BACK AND USES OR DISCLOSURES ALREADY MADE WITH YOUR AUTHORIZATION. OTHER LAWS PROTECT PHI. YOUR PHI PRIVACY RIGHTS: RIGHT TO SEE AND GET COPIES OF YOUR RECORDS, RIGHT TO REQUEST TO CORRECT OR UPDATE YOUR RECORDS, RIGHT TO GET A LIST OF DISCLOSURES, RIGHT TO REQUEST LIMITS ON USES OR DISCLOSURES OF PHI, RIGHT TO REVOKE PERISSION, RIGHT TO CHOOSE HOW WE COMMUNICATE WITH YOU, RIGHT TO FILE A COMPLAINT, RIGHT TO GET A PAPER COPY OF THIS NOTICE. PLEASE CONTACT LUIS A. ALVAREZ, M.D. OR SANDRA R. ALVAREZ, M.D. WITH ANY CONCERN

I HAVE READ AND UNDERSTAND THIS NOTICE

PRINTED NAME OF PATIENT _____ SIGNATURE _____ DATE ___/___/___

I AGREE TO HAVE _____ **VIEW AND DISCUSS:**
PRINTED NAME OF ASSIGNED DESIGNEE

_____ **MY MEDICAL HISTORY AND CURRENT TREATMENT, MEDICATIONS, DIAGNOSIS, LABS, ETC.**

_____ **BILING: ANY BALANCES, PAYMENTS ETC.**

_____ **OTHER:** _____

SIGNATURE OF HEALTHCARE ASSIGNED DESIGNEE _____ DATE ___/___/___

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NOTICE FOR LABORATORY, IMAGING AND DIAGNOSTIC FEES:

AT TIMES IT MAY BE NECESSARY TO PERFORM LABORATORY WORK, IMAGING OR DIAGNOSTIC TESTS TO CONFIRM, ADIAGNOSIS OR DETERMINE A COURSE OF TREATMENT. IF A BIOPSY, IMAGING OR OTHER LAB WORK IS DONE, YOU WILL RECEIVE A SEPERATE BILL FROM THE IMAGING CENTER OR LABORATORY FOR THESE TESTS. IF YOUR INSURANCE PLAN HAS A PREFERRED PROVIDER FOR BLOOD WORK, IMAGING OR PATHOLOGY, PLEASE NOTIFY OUR OFFICE STAFF PRIOR TO ANY PROCEDURE FOR SPECIAL HANDLING. ALTHOUGH THE LAB AND IMAGING CENTER WILL FILE WITH YOUR INSURNACE COMPANY, ANY BILL YOU MAY RECIEVE FROM THE LABORATORY OR IMAIGING CENTER SHOULD BE DISCUSSED WITH THOSE INSTITUTIONS. THUS, YOU ARE RESPONSIBLE FOR THE SPECIFICATIONS OF YOUR INDIVIDUAL PLAN, AND WHAT BENEFITS ARE COVERED AT THE TIME OF SERVICE.

I UNDERSTAND THAT I, THE PATIENT OF BOCA RATON FAMILY AND PEDIATRIC CENTER, ARE SOLELY RESPONSIBLE FOR ANY CHARGES THAT ARE INCURRED BETWEEN THE LABORATORY/IMAGING CENTER AND MY INSURANCE COMPANY. I UNDERSTAND THAT IT IS MY FULL RESPONSIBILITY TO ACKNOWLEDGE AND UNDERSTAND THE SPECIFICATIONS OF MY INDIVIDUAL PLAN, AND WHAT BENEFITS ARE COVERED AT THE TIME OF SERVICE. **I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO MAKE A FOLLOW UP APPOINTMENT WITH DR. ALVAREZ OR DR. SANDRA ALVAREZ TO DISCUSS ANY TEST RESTULS; THUS NO RESULTS WILL BE GIVEN OVER THE PHONE.**

I HAVE READ AND UNDERSTAND THIS NOTICE

PRINTED NAME OF PATIENT _____ **SIGNATURE** _____ **DATE** ___/___/___

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WALK-IN POLICY

YOUR NAME HAS BEEN PLACED ON A LIST OF PATIENTS WAITING TO SEE THE DOCTORS. DUE TO OUR HIGH VOLUME OF PATIENTS WITH APPOINTMENTS AND WALK-INS, THERE IS A CHANCE THAT WHEN YOU ARE A WALK-IN THAT THERE MAY BE A WAIT. PLEASE KEEP IN MIND THAT WE BRING BACK WALK-IN PATIENTS ON A FIRST COME, FIRST SERVE BASIS. WE CAN TELL YOU HOW MANY PATIENTS ARE WAITING AHEAD OF YOU. WE DO NOT KNOW HOW LONG THE WAIT WILL BE (EVERY PATIENT REQUIRES A DIFFERENT ATTENTION). WE WILL ALWAYS DO OUR BEST TO MAKE YOUR EXPERIENCE ENJOYABLE AND TO HAVE YOU RECIEVE CARE AS QUICKLY AS POSSBLE. **BLOOD DRAWS ARE BY APPOINTMENT ONLY.** WE ENCOURAGE PATIENTS TO SCHEDULE APPOINTMENTS AS WE DO UNDERSTAND YOUR TIME IS VALUABLE.

I HAVE READ AND UNDERSTAND THIS NOTICE

I ,_____ HAVE READ AND UNDERSTAND THE
PRINTED NAME OF PATIENT

TERMS ABOVE IF I WERE TO BE A WALK -IN

_____ ____/____/____
SIGNATURE **DATE**